Oranga Tamariki Residence Visit

Office of the Children's Commissioner

OPCAT Monitoring – Unannounced visit

Epuni Care and Protection Residence

Visit date: 9(2)(a) [redacted]

Report date: 9(2)(a) [redacted]

Contents

Introduction

Purpose of visit

The purpose of this visit was to fulfil the international monitoring mandate of the Office of the Children's Commissioner (OCC), to monitor the safety and wellbeing of children and young people detained in secure locked facilities.

The Children's Commissioner is a National Preventive Mechanism (NPM) under the Crimes of Torture Act (1989)[1]. The role of OCC is to visit care and protection and youth justice residences to examine the conditions and treatment of children and young people, identify any improvements required or problems needing to be addressed, and make recommendations aimed at strengthening protections, improving treatment and conditions, and preventing ill treatment. For more information about the legislative context for our visits, see Appendix One.

Context

Between 9(2)(a) staff from the Office of the Children's Commissioner carried out an unannounced monitoring visit to Epuni care and protection residence in Lower Hutt, Wellington. This is the first time OCC has made an unannounced OPCAT visit, outside our usual schedule, for the specific purpose of following up safety concerns.

The reasons for this unannounced visit were as follows:

- During our OPCAT monitoring visit of 9(2)(a) we identified serious concerns about the safety of the children and young people. We were particularly concerned that children and young people were not safe from themselves or others.

- On 9(2)(a) we met with members of the Epuni management team and described our concerns, including those about the safety of children and young people.

- On 9(2)(a) we emailed our draft monitoring report which included the above concerns, to Oranga Tamariki, for their consideration and feedback.

- On 9(2)(a) we met with managers from Oranga Tamariki to reach agreement on the accuracy of the draft report and recommendations contained within it.

- On 9(2)(a) we emailed the final version of our report containing the same safety concerns and the agreed recommendations to Oranga Tamariki.

[1] This Act contains New Zealand's practical mechanisms under the United Nations Convention Against Torture and other Cruel, Inhuman, or Degrading Treatment or Punishment (OPCAT). https://www.occ.org.nz/our-work/monitoring/monitoring-work/why-we-monitor/

- In April 2021 we were contacted by a person who wished to remain anonymous describing serious concerns about the safety of children and young people at Epuni care and protection residence.

- In May 2021 we were contacted by a relative of a young person at the residence who had been unable to contact them by phone, despite repeated attempts, and was concerned about their wellbeing.

As a result of these events, we decided to make an unannounced visit to follow up on our previous concerns, investigate the matters raised by members of the public and assess any progress made on our recommendations. This visit was scheduled for 9(2)(a)

On 9(2)(a) we then received a letter 9(2)(a) . The letter identified safety concerns for 9(2)(a) and the impact this was having on themselves, their whānau and staff.

Children and young people at Epuni

Epuni has capacity for 10 children and young people. There were 9(2)(a) children and young people staying at the residence at the time of our visit. Their ages ranged from 9(2)(a)

Our monitoring process

We were interested in hearing about the experiences of children and young people and to talk to staff about any progress since our last visit.

We spent time observing children, young people and staff in the unit and having informal conversations with them. We conducted one-to-one interviews with children and young people who chose to talk with us. We also spoke with some residence staff by phone and/or face-to-face and reviewed relevant documentation.

For more information about our interviews and other information gathering processes see Appendix Two.

Our evaluation process

We analysed the information we gathered by identifying the common themes in relation to the treatment and conditions experienced by children and young people. We then coded our data using qualitative data analysis software then identified any further themes. These themes had a strong alignment to our focus areas for this visit.

We use key descriptors – harmful, poor, good and very good – to describe our overall findings in relation to:

- the treatment of young people at the residence
- the conditions at the residence

The table below lists the descriptors used in our findings, describing their impact and our expectations for further action.

Finding	**Impact for young people**	**OCC expectation**
Harmful	Treatment and/or conditions that are damaging or hurtful for children and young people	Must be urgently addressed
Poor	Treatment and/or conditions that are not sufficient to meet the needs of children and young people	Requires improvement in the near future
Good	Treatment and/or conditions that are sufficient to meet the needs of children and young people	Must be reviewed regularly to ensure the standard is maintained and improved if possible
Very good	Treatment and/or conditions that work well to meet the needs of children and young people	Should continue subject to effectiveness. May also be beneficial in other residential contexts

Overall findings

We found five key areas that require urgent attention. These areas were identified as 'harmful' because they have a significant impact on the safety and wellbeing of children and young people at Epuni. The areas are:

- Staff unable to keep children and young people safe from their peers or themselves
- Children and young people being harmed by staff
- Staff unable to provide adequate care for children and young people with complex mental health needs
- Staff levels insufficient to keep children and young people safe
- Whānau unable to make contact with their child or young person

On 9(2)(a) May 2021 we informed the Epuni Residence Manager, National Residential Service Manager and General Manager Care and Protection Residences about the areas identified, requesting a time to meet with them about these issues, and the need for these issues to be addressed immediately.

As a result of this visit, our Office also made a Report of Concern to Oranga Tamariki, about the safety, care and treatment of a young person after disclosures were made to our staff during the visit.

Recommendations

All the recommendations we identified in our 9(2)(a) OPCAT report remain.
We have identified additional recommendations for Oranga Tamariki. These are identified in the table below.

Oranga Tamariki National Office **We recommend that the DCE Care Services:**	
Rec 1:	Urgently provides the action plan requested by OCC, which responds to the concerns outlined to Oranga Tamariki on 9(2)(a) May 2021 and in this report. Support is given to the Epuni residence team to execute this action plan. **September Update** A letter from the DCE Governance and Engagement, Oranga Tamariki was received with updates on actions undertaken to support the recommendations provisionally made by OCC. An Epuni Safety Plan was also received on 9 September 2021 by OCC.

Epuni care and protection residence We recommend that the residence leadership team:	
Rec 2:	Executes the action plan and keeps record of progress (with specific reference to Recs 3, 4 and 5)
Rec 3:	Prevents children and young people from being physically assaulted by staff members and their peers. (Ref. page 7)
Rec 4:	Urgently trains and recruits staff with specialist knowledge and skills to effectively support children and young people with complex mental health needs. (Ref. page 9)
Rec 5:	Analyses staff turnover to better understand reasons for leaving, any patterns and to improve the retention of staff. (Ref. page 10)
Rec 6:	Ensures phone calls between children and young people and their whānau: a) occur in a timely way b) are able to happen by ensuring the acoustics and phone equipment within the residence allow for clear, private and quality communication. (Ref. page 10)

Findings from this visit

Staff were unable to keep children and young people safe from their peers

- Children and young people said they continue to feel unsafe at Epuni. Most of this was due to the inability of staff to protect them from intimidation and assaults by individuals and groups of other children and young people.
- Children and young people described being anxious, scared and powerless as a result of previous incidents where staff had failed to protect them.
- We heard about children and young people being assaulted by another young person multiple times.
- Children and young people told us about other children and young people being incited to undertake assaults on others.
- Several weeks prior to our visit, children and young people were split across two wings as they were feeling unsafe around another young person. Two staff were rostered on each wing with one staff member floating between the two groups.
- At the time of our visit, children and young people had been brought back to one wing 9(2)(a) [redacted] Despite this, safety remains an issue.

9(2)(a) [redacted]

Staff were unable to keep children and young people safe from themselves

- Children and young people continued to worry about their ability to keep themselves safe in the residence environment. This concern was echoed by staff.
- The frequency of self-harming and suicide attempts had increased since our last visit in 9(2)(a) [redacted] Serious Event Notifications made by Epuni staff between 9(2)(a) [redacted] show that 9(2)(a) [redacted] events related to suicide attempts. 9(2)(a) [redacted] We heard from staff the suicide attempts and self-harm had "never been so serious" with some that could have resulted in fatalities.
- Staff told us about the stress of coming to work and constantly witnessing strangulation attempts and/or struggling to remove ligatures.
- One staff member described their daily goal being no deaths on their shift.
- Staff, children and young people described 'copycat' behaviour where a single incident of self-harm would spread among several children and young people in the residence.
- We were told about frequent ambulance call outs, including three separate call outs in one day, due to self-harming and suicidal attempts.
- We heard about the frequent use of Hoffman knives to remove life threatening ligatures.
- We read and heard of periods when more than half the children and young people were the subject of 30 minute or five-minute observations.

9(2)(a) [redacted]

Staff were struggling to provide care for children and young people with complex mental health needs

- Children and young people said they felt like staff did not take their mental health concerns seriously. They talked about staff referring to self-harming behaviour as 'stupid' and 'attention seeking' and those involved in widespread self-harm, as 'sheep'.
- Staff described struggling to care for mentally and emotionally distressed children and young people. They felt powerless in constantly responding to potentially fatal situations without specialist training or support. We heard this affected them physically and emotionally, resulting in low morale among staff. They said management hadn't provided sufficient support in dealing with these situations.

9(2)(a) [redacted]

Children and young people described staff assaulting and illtreating them

- 9(2)(a) [redacted] unable leave their bedroom at night to get a drink or use the bathroom as staff did not permit it. We also heard of staff using other young people as a threat to physically hurt other children and young people.
- We heard about times when there were no female staff members rostered onto the night shift. This is concerning, given some children and young people's plans clearly stipulate night-time checks are to be undertaken exclusively by female staff.
- We heard about examples of restraints. Children and young people said sometimes staff ''fight back'' when restraining them and that restraints can hurt.

9(2)(a) [redacted]

Staff levels were insufficient to provide safe care for children and young people

- Children, young people and staff talked about the difficulties staff were experiencing in managing children and young people.
- Children and young people said they do not get quality time with staff as staff need to respond to other things going on in the unit.
- We observed the difficulty for staff in trying to manage the floor and keep constant line of sight for all children and young people.
- Only 9(2)(a) casual staff were available in the casual pool at the time of our visit. We understand there has been a recruitment drive to try and increase the casual pool.
- There was a high turnover rate of permanent staff. Data we requested shows that 9(2)(a) permanent staff members had left Epuni since 9(2)(a) Exit interviews have not been undertaken so the reasons for staff leaving are not known. Some of the roles have since been filled, and some remain vacant or are temporarily filled.
- We heard how low staffing levels and the need to use the casual staff regularly, and the departure of experienced staff members impacts on safety and staff morale. Staff also talked about needing to work long hours to cover shifts.

9(2)(a)

[redacted]

Children and young people's ability to contact their whānau and people close to them was extremely variable

Problems included:

- whānau phone calls not being answered at the residence
- whānau phone calls not being put through to children and young people
- inconsistent practice in relation to the length of phone calls to whānau – some said their calls were limited to five minutes while others were able to talk for longer periods

- staff being unavailable to pick up or supervise phone calls due to programmes running over time or other competing activities
- variability in the children and young people's experiences due to the quality of the phones making it hard to hear well
- the unit not having enough phones for children and young people to have adequate calls
- the acoustics in the unit made it almost impossible for whānau and professionals to hear children and young people and vice versa

Follow up actions

We heard from 9(2)(a) about their experiences of harm from staff. As a result of hearing this information, we undertook the following actions:

- On 9(2)(a) May 2021 we met with the Manager of Epuni Residence to talk through concerns we had about the safety of one young person from staff. We also contacted Oranga Tamariki National Office staff about these concerns.
- On 9(2)(a) May 2021 we made a Report of Concern to Oranga Tamariki regarding these safety concerns.
- On 9(May 2021 we met with the National Residential Service Manager and General Manager Care and Protection Residences including the Deputy Chief Executive Care Services to talk through these issues and to understand how they would address the concerns and placement options for a young person. We also requested a written plan identifying the actions that would be taken. 9(2)(a)
- On 9(2 July 2021 we emailed Oranga Tamariki to seek an update on the outcome of the Report of Concern.
- On 9(July 2021, we received an email from Oranga Tamariki, stating the investigation had been completed, and Oranga Tamariki were working on making a finding. We received a second email stating Oranga Tamariki were unable to provide OCC with details of the investigation but we were made aware of the outcome.
- On 9(September 2021 we received a letter from the DCE, Governance and Engagement for Oranga Tamariki with an update of actions taken since the visit and a copy of the Epuni Safety Plan

Progress on OCC recommendations from March 2021 monitoring report

Where the recommendations from the previous visit were a focus for this visit, progress against these are detailed below.

It should be noted that whilst writing this report, further updates regarding actions undertaken by Oranga Tamariki against recommendations from the 9(2)(a) report were received in September 2021 along with the Epuni Safety Plan. Progress against the full list of recommendations will be formally reported in the next monitoring report for Epuni.

We recommend that the DCE Care Services:	
Rec 7:	Supports the residence to ensure that any children and young people who are placed there are: • compatible in terms of their individual and group needs, and • able to be kept physically and emotionally safe within the residence environment. **May 2021 update** *Since our last visit, the residence has failed to ensure that children and young people, placed together at the residence, are compatible in terms of their individual and/or group needs. Children and young people have not been kept physically or emotionally safe within the residence environment.*

Epuni Residence **We recommend that the residence leadership team:**	
Rec 9:	Ensures staff continue to be trained in specialist knowledge and skills so they can respond effectively to children and young people with complex mental health needs. **May 2021 update** *Since our last visit, staff have struggled to provide care for children and young people who have complex mental health needs.*
Rec 12:	Increases the number of care staff on the floor to ensure staff and children and young people feel safe and supported, and staff can focus on the individual needs of children and young people. *(Ref. page 19) (Ref. State of Care 2017, action 15)* **May 2021 update** *Since 9(2)(a) staffing levels have not always been sufficient to provide safe care for children and young people.*

Rec 13:	Continues to review all use of force to ensure the appropriateness of the action and uses these reviews as learning opportunities for staff. *(Ref. page 9 OPCAT report March 2021)* **May 2021** *This was not a particular focus for this visit, however, it is now an urgent recommendation given that children and young people alleged that staff had assaulted and ill-treated them.*

Appendix One: Why we visit – legislative background

The Office of the Children's Commissioner is designated as a National Preventive Mechanism (NPM) under the Crimes of Torture Act (1989). This Act contains New Zealand's practical mechanisms for ensuring compliance with the United Nations Convention Against Torture and other Cruel, Inhuman, or Degrading Treatment or Punishment (OPCAT). The convention was ratified by New Zealand in 2007. Our role is to visit secure youth justice and care and protection residences to examine the conditions of the residences and treatment of children and young people, identify any improvements required or problems needing to be addressed and make recommendations aimed at improving treatment and conditions and preventing ill treatment.

In addition, the Children's Commissioner has a statutory responsibility to monitor and assess the services provided under the Oranga Tamariki Act 1989. Specifically, section 13(1) (c) of the Children's Commissioner Act 2003, states that the Commissioner must monitor and assess the policies and practices of Oranga Tamariki and encourage the development of policies and services that are designed to promote the welfare of children and young people.

Appendix Two: Interviews and information gathering

We formally interviewed:

- [redacted]children and young people
- 9(2)(a) [redacted] Manager

We also spoke with a number of internal staff and external stakeholders (5+) which informs our findings.